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CONTENTS

Cover Story

Competing in a Shifting Marketplace

To lend a hand to nurses who want to bring about changes in the health care system, author Sandra R. Edwardson analyzes why competitive forces are working in the area of maternity services. **Page 72.**

Features

78

Rural Health Clinic

The authors surmounted formidable obstacles to set up a rural health clinic that's meeting their clients' needs.

Sister Sally Griffin
Sister Dorothy Peterson
H. Terri Brower

96

AD Education

As the number of associate degree nurses grows, the author looks at the important roles they play.

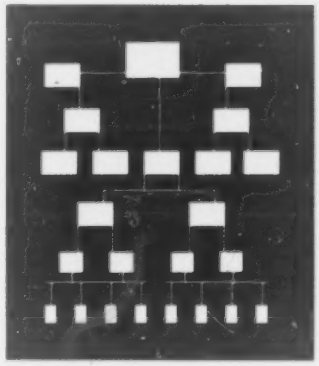
Elizabeth K. Wajdowicz

84

Students as Ombudsmen

This unique clinical practicum is helping RN baccalaureate students learn to be leaders.

Susan E. Gordon

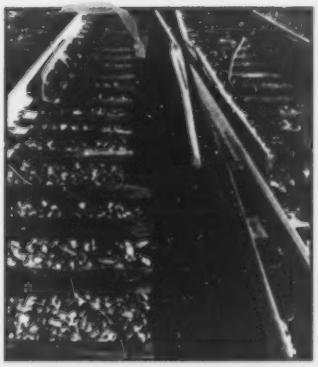


100

Organization Design

The author considers the organization design task as it relates to the quality assurance function.

Ruth Barney Fine



90

Tracking Down the Right Degree

A look at whether the nursing job market demands advanced degrees for leadership positions.

Priscilla A. Butts
Barbara Agress Berger
Dorothy A. Brooten

Departments

59 Guest Editorial
61 NLN Perspective
68 News
70 Washington Focus
105 Accredited PN Programs
109 NLN Calendar
111 Classified

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NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Tracking Down the Right Degree for the Job

PRISCILLA A. BUTTS
BARBARA A. BERGER
DOROTHY A. BROOTEN

Do nurses need bachelor's, master's, or doctoral degrees to do their jobs well, to keep those jobs, or to advance their careers? The Institute of Medicine's (IOM) report on nursing and nursing education partially answered these questions, which the American public, physicians, and nurses themselves often ask [1]. When they examined the need for nurses in the future, the IOM committee concluded that a wide range of problems could only be alleviated by substantially increasing the supply of nurses with advanced degrees. The group noted that today's complex health care settings demand managers who are skilled not only in nursing but also in decision making and in resource management. They had found a widespread conviction among administrators of hospitals and long-term care facilities that nurse administrators could make care delivery more cost effective if they had better grounding in financial management and in the human resource management required at all levels of nursing administration — from head nurse positions through nursing service administration.

The committee also said that the competencies of nurses who provide bedside care depend to a large extent on the capabilities of their teachers, who must, within a short period of time, help students acquire the theoretical knowledge and clinical experiences needed to become competent professionals. The group noted that many nurse educators are inadequately prepared to accomplish this goal. They cited comparisons between the academic preparation of nursing faculty and that of faculty in other disciplines to support their argument. They also said that, although well-qualified generalist nurses can deliver care effectively, increasingly complex care presents problems that require the specialized knowledge and experience of nurses with advanced degrees.

Although this report, as well as others before it, pointed out a need for advanced educational preparation for nurses, many nurses still question whether such a need has created requirements to fulfill it [2–4]. Does the nursing job market demand advanced educational preparation for leadership positions in nursing service and in nursing education? Have the educational requirements for these positions changed over the past 10 years? To answer these questions, we analyzed the classified advertisements of each issue of seven journals in 1972, 1977, and 1982, looking for changes in required educational degrees for positions in educational administration in nursing, faculty positions, and a variety of leadership positions in nursing service.

Methods

The journals we surveyed were the *American Journal of Nursing; Nursing Outlook; RN; Nursing '72, '77,* and *'82; The Journal of Nursing Administration*; the 1977 and 1982 issues of *Nurse Educator*, since the journal was not in publication in 1972; and *Supervisor Nurse*, which later became the *Journal of Nursing Management*. We selected these journals because they had a large circulation or were distributed to a large population of either nurse administrators or nurse educators.

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Table 1. Educational Requirements for Positions in Educational Administration, 1972, 1977, 1982

	Total N	Doctorate Required	Doctorate Preferred	MSN Required
Dean				
1972	19	47%	53%	
1977	69	83	14	3%
1982	24	67	29	4
Associate or Assistant Dean (Graduate)				
1972	10	20%	80%	
1977	40	93	7	
1982	18	67	33	
Associate or Assistant Dean (Undergraduate)				
1972	8	25%	50%	25%
1977	87	74	24	2
1982	11	45	55	
Department Chair or Head				
1972	28	29%	46%	25%
1977	124	62	30	8
1982	56	71	18	11

We analyzed the classified advertisements of each issue of the seven journals, but we did not include either advertisements that did not mention degree requirements, or house ads, which are general ads for a particular hospital or agency and do not focus on specific positions.

The positions we analyzed in nursing education administration included: dean; assistant or associate dean for graduate studies; assistant or associate dean for undergraduate studies; and department chair or department head, which included both heads or chairs of departments of nursing as well as heads or chairs of clinical specialty programs. Faculty positions included faculty of graduate and undergraduate programs.

We categorized positions in nursing service into director of nursing; assistant or associate director of nursing; clinical director; supervisor; head nurse; clinical specialist; inservice educator; and consultant. Initially, we also included assistant head nurse and staff nurse, but the number of classified advertisements that described required degrees for those positions were negligible and did not warrant inclusion.

Findings

From 1972 to 1982, demand for advanced degrees increased for advertised positions in educational administration in nursing, for nursing faculty positions, and for most positions in nursing service.

Education Administration

From 1972 to 1982, the advertisements showed a clear shift from preference for a doctorate to a required doctorate for positions in educational administration. Surprisingly, a greater percentage of ads that required a doctorate for positions as deans and assistant and associate deans for both graduate and undergraduate programs appeared in 1977 than in 1982 (see Table 1). The 1982 figures may reflect market realities, since, by then, the numbers of both master's and doctoral programs in nursing had increased, creating competition for the limited pool of people prepared at the doctoral level to teach in such programs.

Our analysis showed that the market has generally demanded more than a master's degree for a dean position. While the percentage of ads that indicated a preference for a doctorate decreased from 53 percent in 1972 to 29 percent in 1982, the ads that listed doctorates as required increased from 47 to 67 percent.

Ads for assistant and associate deanships indicated that a greater percentage of graduate programs than undergraduate programs required a doctorate in 1982. In 1972, the greatest percentage of ads for assistant or associate deanships at the graduate level indicated a preference for the doctorate; 10 years later, the greater percentage required a doctorate. In contrast, the highest percentage of ads for assistant or associate deans for undergraduate programs indicated preferences for doctorates both in 1972 and in 1982. This finding may have reflected the small number of advertisements for undergraduate deanships — only 11 — or possibly a marketplace phenomenon in which deanships at the graduate level were better able to attract doctorally prepared individuals than are deanships at the undergraduate level.

Degree requirements for positions as department chairs or heads also changed markedly from 1972 to 1982. In 1972, a master's degree was a viable credential; in 1982, it remained so for a limited number of positions. The shift toward requiring a doctorate was most dramatic. In 1982, the greatest percentage of ads that called for doctoral degrees for positions in educational administration were in this category.

The journals we surveyed showed a decrease from 1972 to 1982 in the demand for master's degrees for positions in educational administration. And, although there was an increase in the number of ads that indicated required doctorates, there were fewer that read "doctorate preferred" for most educational administration positions. An exception to this trend was a 5 percent increase in preferred doctorates for positions as assistant or associate deans in undergraduate nursing programs. Although we found a greater percentage of ads that required doctorates in

three of the four categories in 1977, that may have represented unrealistic market expectations given the growing number of graduate and baccalaureate programs being established during that period.

For example, in 1976, there were 15 doctoral programs in nursing. Five universities had nurse-scientist training programs that offered doctorates to nurses in such areas as anthropology, physiology, and sociology.

Since 1976, doctoral education in nursing has become increasingly available. New programs have been developed, and the programs that existed in 1976 have increased their enrollments. It may now be more realistic to require higher educational standards for both faculty and administrators of nursing schools. If the trend found in these job requirements continues, nurses will need a doctoral degree to qualify for positions in educational administration.

Faculty Positions

Between 1972 and 1982, the number of programs that required advanced degrees for faculty positions increased. Although the change was most dramatic for faculty positions in associate degree and diploma programs, faculty positions requirements for graduate and baccalaureate nursing programs shifted as well.

The requirements listed for graduate faculty positions showed a trend toward preferring doctoral degrees. However, in 1972, 60 percent of the ads for graduate faculty called for doctorates, and in 1982, only 36 percent did. This may suggest that the growing number of graduate programs were unable to draw the number of doctorally prepared faculty they needed.

The ads for baccalaureate faculty positions also showed that programs increasingly either preferred or required a doctorate, rather than only a master's degree. In 1972, 93 percent of the ads for these positions indicated that master's degrees were preferred or required. By 1982, only 38 percent of the ads called for master's degrees, but preference for doctoral degrees increased from 6 percent in 1972 to 56 percent in 1982.

Associate degree programs clearly shifted from preferring that faculty members have master's degrees to requiring those degrees. In 1972, 59 percent, in 1977, 28 percent, and, in 1982, 27 percent of the ads indicated preference. The number of ads that indicated required master's degrees increased from 38 percent in 1972 to 69 percent in 1977 and 68 percent in 1982. Although the ads for faculty positions in AD programs showed that preference for doctorates changed little from 1972 to 1982, in 1982, 1 percent listed doctorates as required.

The ads for positions in diploma nursing programs also reflected a change from preferring to requiring master's degrees. In 1972, only 17 percent of the ads indicated that the programs required master's degrees. In 1977, 38 percent of the ads called for those degrees, and, in 1982, 65 percent. This trend was similar to the one we discovered in AD programs. In 1977, the majority of AD program ads listed master's degrees as required; the overwhelming majority of diploma programs did not indicate that requirement until 1982.

Table 2. Educational Requirements for Nursing Faculty Positions, 1972, 1977, 1982

	Total N	Doctorate Required	Doctorate Preferred	MSN Required	MSN Preferred	BSN Required	BSN Preferred
Graduate Faculty							
1972	30	60%	13%	23%	3%		
1977	306	32	58	10			
1982	192	36	58	5			
BSN Faculty							
1972	365	1%	6%	89%	4%		
1977	855	3%	29	65	3		
1982	454	6%	56	37	1		
ADN Faculty							
1972	242		2%	38%	59%	1%	
1977	277		1	69	28	2	
1982	149	1%	3	68	27	1	
Diploma Faculty							
1972	207			17%	59%	21%	2%
1977	120			38	60	1	1
1982	20			65	30	5	

Nursing Service Positions

Although a master's degree was listed as required in the largest percentage of ads for directors of nursing from 1972 through 1982, there was a slow but steady increase in advanced degree requirements for this position. In 1972, 25 percent of the ads indicated either preferences or requirements for BSNs; the percentage decreased to 8 in 1982. Preferences for master's degrees increased during the same period. Although none of the 1972 ads indicated that doctorates were preferred or required, 3 percent in 1977 and 7 percent in 1982 did. We saw a similar trend in the requirements for assistant or associate directors of nursing.

The 1972 ads for assistant or associate director positions showed that 25 percent of the programs preferred or required BSN degrees. That percentage dropped to 6 in 1982. Although the number of ads that listed master's degrees as preferred increased only slightly, in 1972, 37 percent listed

master's degrees as required, and 50 percent listed that requirement in 1982. None of the 1972 or 1977 ads listed doctorates as preferred or required, but, by 1982, 8 percent did.

We found that the requirements for advanced degrees for such positions as clinical directors also increased slightly between 1972 and 1982. Preferences or requirements for BSNs decreased, while preferences or requirements for master's degrees went up. However, the number of ads that indicated required master's degrees decreased from 53 percent in 1972 to 36 percent in 1982, which may have reflected the condition of the marketplace. In 1977, the ads began to show preferences for doctorates, and, in 1982, 3 percent were from employers who required doctoral degrees for the position.

A small percentage of the ads from 1972 and 1982 indicated that supervisor applicants did not have to have BSNs. Requirements for BSNs increased slightly, and preferences for those degrees decreased dramatically. Forty-seven percent of the 1972 ads and 52 percent of the 1982 ads were placed by employers who either required or preferred master's degrees. "Doctorate preferred" appeared in 2 percent of the ads for supervisor positions in 1982.

In 1972, 29 percent of the advertised positions for head nurses required less than a bachelor's degree. This percentage had decreased to 12 percent in 1982. The ads that listed bachelor's degrees as required increased, as did those that indicated preferences or requirements for master's degrees. None of the ads from 1972 through 1982 indicated either preference or requirements for doctorates.

Despite the fact that the American Nurses' Association has said that clinical specialists must have master's degrees, in 1982, 18 percent of the ads we read indicated a preference for those degrees [5]. The number of ads that required candidates to have master's degrees increased slightly over the 10 year period.

Requirements for advanced degrees for positions in inservice education changed only slightly from 1972 to 1982. The number of ads that indicated a preference for a BSN decreased, while those that listed master's as preferred increased only slightly.

Table 3. Educational Requirements for Nursing Services Positions, 1972, 1977, 1982

Director of Nursing								
1972	320			46%	28%	16%	8%	2%
1977	395	1%	2%	43	30	14	8	2
1982	164	3	4	46	35	5	3	3
Assistant Director of Nursing								
1972	172			37%	33%	23%	2%	5%
1977	259			45	32	13	10	
1982	127	2%	6%	50	35	2	4	
Clinical Director								
1972	15			53%	20%	20%	7%	
1977	10		20%	30	30	0	20	
1982	39	3%		36	49	8	5	
Supervisor								
1972	173			23%	24%	22%	25%	6%
1977	273			27	29	20	20	4
1982	103		2%	24	28	29	9	8
Head Nurse								
1972	35			3%	3%	14%	51%	29%
1977	75			16	11	33	35	5
1982	64			3	16	36	33	12
Clinical Specialist								
1972	38			71%	29%			
1977	145			85	12	2%	1%	
1982	102			82	18			
Inservice Educator								
1972	93		3%	23%	27%	24%	23%	1%
1977	61			62	23	13	2	0
1982	34			26	29	24	15	6
Consultant								
1972	35			49%	31%	14%	3%	3%
1977	14			93	7			
1982	6			83	17			

In 1972, 80 percent of the ads for consultants listed master's degrees as required or preferred, but 20 percent required only a bachelor's degree or less. Since then, master's degrees have clearly been the standard for this position — 83 percent of the 1982 ads called for master's degrees.

Discussion

If the trends evident in the ads we reviewed continue, master's degrees alone will be less viable credentials to qualify for faculty positions in both graduate and baccalaureate programs, and possibly in an increasing number of associate degree faculty positions. This trend is consistent with the movement of nursing education into college and university settings that increasingly require nursing faculty to have the same academic qualifications as faculty members in other disciplines. Programs that prepare nursing faculty at the master's level should be cognizant of this trend.

Contrary to the trend found in other educational programs, none of the ads from diploma schools of nursing listed doctorates as required or preferred. Whether this finding reflects market realities or values different from those of other nursing programs is not clear.

In general, since 1972, employers have been requiring more advanced degrees for directors of nursing, assistant or associate directors of nursing, head nurses, clinical specialists, and consultants. Advanced educational requirements have increased more slowly for clinical directors, supervisors, and, particularly, inservice educators. This finding is consistent with historic education trends in inservice settings. And a 1977 survey by the American Hospital Association to determine a profile of the nation's nurse executives in nursing service indicated that most were educated at the diploma level, with no advanced degrees [6].

In 1983, the National Commission on Nursing called for nurse executives and managers who are qualified by education and experience [7]. Both the commission and the Institute of Medicine committee recognized the pivotal role of nurses in these changing times and recommended that they be educated to provide leadership.

We are not sure why the trend toward more advanced degrees has been slow to have an effect on positions in nursing service administration. Looking at the situation simplistically, we might assume that those in power in hospitals do not want or see the need for nursing service administrators with advanced degrees. We might also ask whether nurses with advanced educations find nursing service administration an attractive career choice. Of course, educational requirements in nursing service have always moved more slowly than those in academic settings. This situation is the same in nursing as it is in other professions. For example, a banker generally has fewer academic credentials than does a teacher of finance and economics.

In 1982, we found ads for positions as directors of nursing, assistant and associate directors of nursing, and clinical directors that listed doctorates as required. None of the ads for those positions from 10 years ago listed required doctorates.

The number of ads for positions in nursing service that required less than a bachelor's degree decreased in three categories — assistant director of nursing, head nurse, and consultant. However, ads that required less than a bachelor's degree slightly increased in three other categories — director of nursing, supervisor, and inservice educator.

Ads for head nurse positions increasingly called for candidates to have bachelor's degrees. At the same time, ads that listed MSNs as preferred increased from 3 percent in 1972 to 16 percent in 1982. We wonder if some nurses who were educated as clinical specialists have taken positions as head nurses. When the role of clinical specialist was first described in 1969, it was called a staff position [8]. Within the past decade, more people have advocated an administrative as well as clinical role for clinical specialists [9,10].

Preferences for master's degrees increased for most nursing service positions. They did not increase for clinical specialists and for consultants because, since 1972, most individuals in those positions have had master's degrees.

Preferences for doctorates increased for directors of nursing, assistant and associate directors of nursing, and supervisors. In 1982, we found ads for positions as directors of nursing, assistant and associate directors of nursing, and clinical directors that listed doctorates as required. None of the ads for those positions from 10 years ago listed required doctorates. Also, 10 years ago, the American Nurses' Association did not offer a certification examination in advanced nursing administration, which requires at least a master's degree for eligibility.

The nurse service marketplace shows an increasing demand for master's degrees and a beginning demand for doctorates. If these trends continue, nurses interested in moving up in nursing service settings will do well to obtain at least master's degrees.

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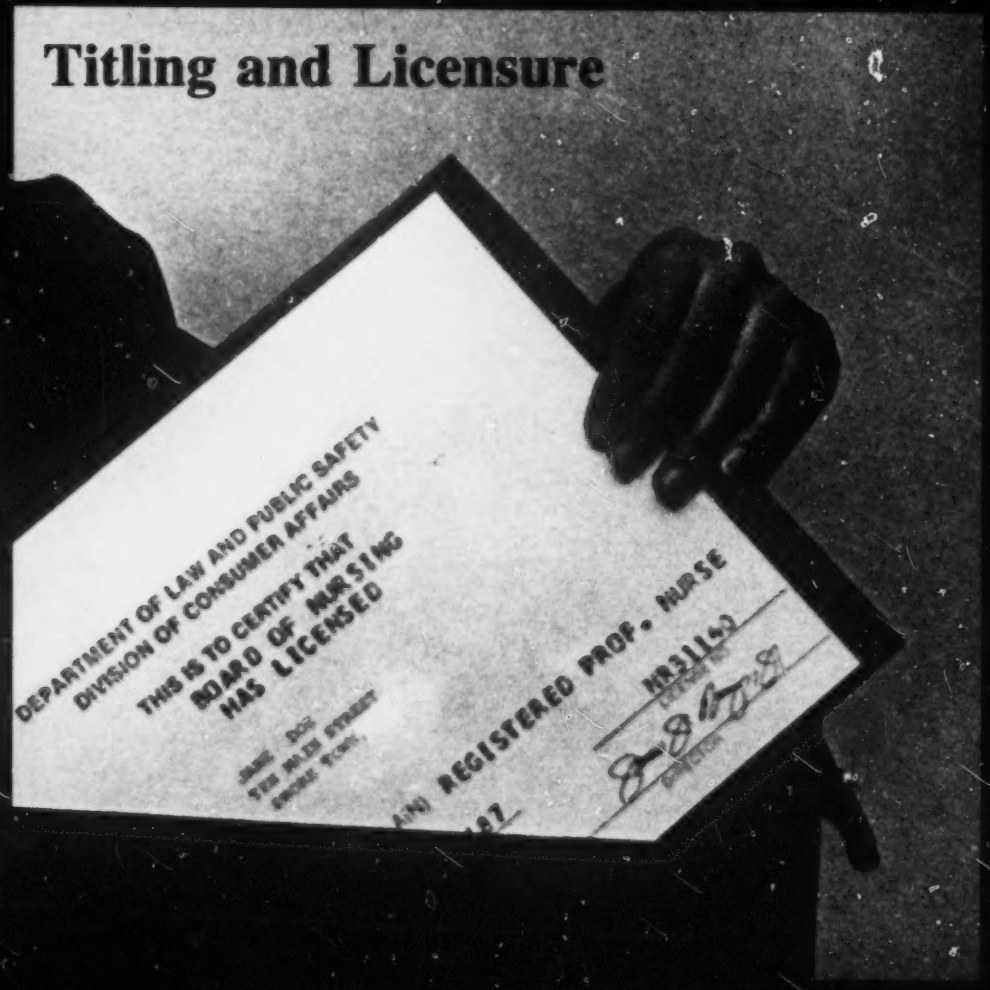
Nursing HEALTH CARE

VOLUME 7, NUMBER 3 MARCH 1986

Titling and Licensure



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VOLUME 7, NUMBER 3 MARCH 1986

CONTENTS

Cover Story

Titling and Licensure

To begin our in-depth treatment of ten trends to watch, three of this month's authors delve into the issue of entry into practice from their points of view. **Pages 130,134, and 142.**

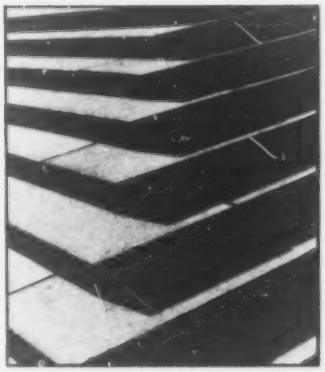
Features

130

NCNIP

The author explains the role the National Commission on Nursing Implementation Project will likely play in guiding nursing's future.

Vivien DeBack

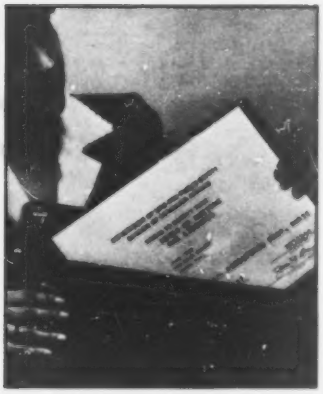


148

Step-by-Step Decision Making

Decision analysis is a tool nurses can use to help them make clinical decisions, says the author.

Sheila Corcoran



134

A First for the Nation

North Dakota recently became the first state to institute two levels of entry into practice. The authors chronicle the process required for bringing about the change.

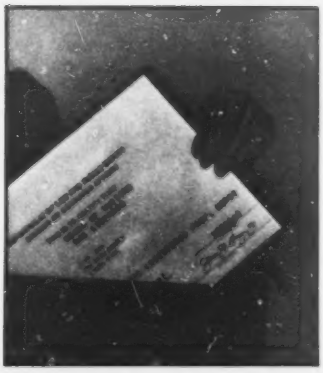
Mary Wakefield-Fisher
Mary M Wright
Lee Kraft

156

Telephone Skills

This nursing school found a unique way to help primary care nurse practitioner students sharpen their telephone techniques.

Linda Schoonover Smith
Peter Curtis



142

RN Licensure for ADN Grads

For a variety of economic and political reasons, the author argues that RN licensure should be retained at the AD level.

Verle Waters

Departments

115 Guest Editorial
116 Announcements
119 NLN Perspective
124 News
128 Washington Focus

New Department:

161 The Marketplace
163 Consumer Capsules
164 Bookends
165 NLN Calendar
167 Classified

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Restricting the RN License to BSN Graduates Could Cloud Nursing's Future

VERLE WATERS

Although nursing leaders have worked toward establishing the bachelor's degree as the entry requirement for professional nurses for most of this century, the American Nurses' Association (ANA) has pursued that goal with growing zeal since the late 1970s. Efforts to differentiate two levels of education and practice in nursing — professional and technical — began in the middle of the century with the establishment of associate degree nursing education. Those efforts, however, were led by educators, and, for the most part, were limited to specifying educational differences; no substantive work role differences or differential job specifications were demonstrated or documented. The absence of differential work roles and rewards in employment between associate degree and baccalaureate graduates, coupled with the relatively greater numbers of graduates from associate degree over baccalaureate programs — about two to one — has created a serious obstacle to nursing's advance toward professionalization.

Introducing a dramatic new component in the organization's formal stance, the delegation to a July 1985 meeting of the ANA adopted a set of resolutions that address the long-held educational goals. Although not different in general purpose, the 1985 resolutions specify legal titles and set forth positions that, to be achieved, require changes in legal requirements for nursing licenses. The effect of the change in legal requirements would be to end the access graduates of associate degree and diploma programs now have to the license for and the legal title of *registered nurse*.

This is not an auspicious time to initiate either legislation or statutory regulations that change educational requirements for the license for and title of RN. The educational goal of setting the bachelor's degree in nursing as minimum preparation for professional nursing practice is desirable, appropriate, and socially constructive. But the strategy to implement that goal by changing laws or regulations in all states by 1995 is inappropriate, counterproductive, and socially irresponsible.

Questions of timing and strategy deserve examination apart from discussion of the overall objective. Even assuming general agreement on the goal that preparation for professional nursing will be a minimum of a baccalaureate degree, and that preparation for technical nursing will be the associate degree, still, proposed and implied strategies and their consequences have not yet been adequately examined and discussed by the nursing community. How does the strategy fit with present and near-future educational resources and with current economic values and constraints? What are the risks and consequences of political failure in enacting the strategy? If success in enacting the licensing changes is possible, are there, even then, potential undesirable consequences?

Educational Resources

The current system of nursing education is poorly positioned to support the ANA's proposed strategy. Looking at the full range of educational programs leading to a license in nursing, only 19 percent of new nursing graduates are prepared in programs that offer bachelor's or higher degrees. "Educational remapping" is needed to provide a basis for enacting legislative and regulatory changes [1]. Figure 1 shows the 1983-1984 "map."

Nearly twice as many RNs who graduate each year have associate degrees or diplomas than have baccalaureate or higher degrees. If, as called for in the ANA implementation strategy, AD, diploma, and LPN/LVN graduates are all licensed at a non-RN level, and if we assume the continuation of the current educational map, second level nurses will outnumber first level nurses by a ratio of 4:1.

What is the desirable ratio? Is it 1:1, as called for in the projection of nursing requirements submitted to the pres-

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ident and Congress in 1984; 4:1, as Mildred Montag hypothesized when ADN education was established; or an average of one LPN/LVN to each three RNs, as was the actual case in acute hospitals in July 1984 [2–4]? Even without an agreed-on standard, few would argue for continuing the current proportions.

The question is, what comes first? Is it first necessary to undertake educational remapping to a point where programs and students are better positioned to support legal changes, or do we first enact new legal standards and expect the educational system to follow? It is important to be realistic as we try to picture future responses to today's actions; in this case, that means critically scrutinizing the expectation that, as a result of legislative and regulatory change of educational requirements for the RN license, both programs and students will achieve institutional relocation such that sufficient numbers in the appropriate, if undefined, mix graduate each year. Such an expectation is largely speculative, not supported by past and present trends and events.

In general, past trends are the best predictors of future events. In nursing education, those trends suggest an approximate continuation of the current proportion of new RN program graduates: 55 percent AD, 30 percent baccalaureate, and 15 percent diploma. If the full range of programs preparing students for a license in nursing is considered, the proportion of graduates each year is: 19 percent BS and higher, 10 percent diploma, 36 percent ADN, and 34 percent LPN/LVN.

Proponents of the strategy to actively pursue the change in legal requirements for the RN license within the next decade expect that the educational system will accommodate the change in a timely fashion. They make two assumptions: there will be a voluntary shift among nursing students toward baccalaureate level education, and, secondly, the growing surplus of non-baccalaureate nurses in the labor market will foster relocation of programs in higher education.

*Figure 1. Nursing Programs Enrollments and Graduations, 1983–1984**

Type of Program	# of Programs	Enrollments	Graduations
LPN/LVN	1225	46,712	41,881
ADN	777	104,806	44,394
Diploma	273	37,256	12,200
BSN (Generic)**	427	95,008	23,718

*Source: National League for Nursing
**Generic MSN and ND programs are included in this category.

Although it seems to make sense that widely publicized enunciation of the bachelor's degree standard in nursing would cause a shift in students' program choices, and that nursing programs would enlarge or contract accordingly, the choices students and institutions make are more complex than might appear at first glance. We know that the demographic characteristics of nursing students in associate degree, diploma, and baccalaureate programs differ. It is also true that the characteristics that distinguish the three student groups are related to their choice of program type; in most cases, to the extent of limiting their choice of program to a single type. In those instances, choice between types of nursing programs does not exist; it is a choice between nursing in a particular type of program or not nursing. It is possible that baccalaureate programs will not attract sufficient numbers of students to maintain the needed supply of new RNs each year.

With regard to institutional decisions, student demand is only one of several factors that influence the existence and extent of a particular type of program. During the last decade, student demand for baccalaureate level nursing preparation substantially exceeded the availability of enrollment opportunities in colleges and universities that offer a BS in nursing. Apparently, resource constraints limited program expansion even in the face of increased student demand. We should not assume that baccalaureate programs can easily or quickly expand to make up for the loss of new RNs annually that would result from the change in legal requirements.

Proponents of the new strategy also voice the assumption that, if associate degree programs close, financial support of baccalaureate education will be enhanced by the diversion of money from closing programs to continuing programs. Within the intricate pathways of monetary politics in higher education, there is little reason to believe that would or could occur, except in those few institutions where both AD and BS programs are offered within a single administrative unit.

A force that could change the educational topography in nursing is a shift from nursing shortage to nursing surplus. The shortage gave rise to the deliberate introduction of the associate degree program, and moved it from the status of a dubious educational experiment to the dominant component of the educational system. If we are, as some predict, now entering a sustained period of surplus, how will it effect the educational map?

Community colleges, in which 90 percent of associate degree nursing programs are located, are, for a number of good reasons, more sensitive than are four-year colleges and universities to changing employment conditions as they set up and break down career training programs. A three- or four-year period in which a significant number of community college graduates fail to find employment in nursing would lead to lowered class sizes. If a falling job market were accompanied by a substantial decline in student applications, programs would close.

The *if* in this discussion may, however, be volatile. Some observers see the indications of a surplus as transitory and predict that a recognized shortage will soon replace the current ambiguity. New work arenas are emerging for nurses and performance demands are changing. Whatever the

There is not yet any evidence that longer, more costly nursing education results in added quality or quantity in nursing care. Before we argue the licensure issue before legislative bodies and regulatory boards, let us direct energy toward studies to provide economic data with which to make the case for change.

future of the job market, it is certain to influence nursing education at all levels. Community colleges see nursing as a successful, significant, socially important occupational program and support it as long as there are job opportunities for graduates and eligible student applicants.

There are indications that a greater number of ADN graduates now accept first positions in long-term care than in previous years. The movement of more new RNs into extended care facilities promises to affect the quality of care in those settings over time. With 777 ADN programs throughout the country, and with a pattern of graduating nurses who remain to work in their communities, associate degree nursing is well positioned to place an increasing number of nurses in community nursing homes. If, however, these graduates are awarded credentials below the level of RN, their ability to make an impact will be markedly reduced. On the other hand, given the present educational map, it is unlikely that there will be enough baccalaureate graduates to extend the range of new graduate positions they take into nursing homes.

For all of the above reasons, the direction set by the ANA should allow more time for clarity and certainty about trends and outcomes of current permutations in health care delivery before initiating changes in legal requirements for licensing nurses.

Educational remapping should occur before eligibility requirements for the RN license are changed, lest a severe reduction in the number of new work force entrants with the legal title RN occur. The need for increasing the numbers of nurses prepared at baccalaureate and higher levels is of unparalleled importance. Styles and Holzemer make these recommendations for educational remapping:

- The national organizations must work in concert to develop and support a national plan to achieve the educational remapping required.
- Regional and state planning must occur. Master plans for nursing education should name numbers, schools, programs, enrollments, etc.
- Schools should operate conscientiously within these master plans [5].

Economic Constraints

Given today's economic climate, it may be undesirable to undertake a change that costs more. The nursing initiative to require the bachelor's degree for RNs carries with it the added costs for students and for society. A student's educational costs, including lost income during the years of study, are clearly higher for longer programs. Society carries a share of those education costs, and loses the benefits of economic productivity during students' period of full-time study. The challenge becomes one of justifying the added costs in terms of benefits to students — higher earning power sufficient to offset higher education costs — and in terms of benefits to society — increased quality or quantity of nursing performance sufficient to offset the higher costs of educating nursing students.

Although nurses with bachelor's degrees do command slightly higher salaries, the differences are not great enough to offset the added costs of education [6]. From the point of view of society's investment in education, there is not yet any evidence that longer, more costly nursing education results in added quality or quantity in nursing care. As Barbara Stevens points out, it is up to nursing to design the educational and practice situations in which the question, "Does the 1985 nursing education proposal make economic sense?" can be answered [7]. Before we argue the issue before legislative bodies and regulatory boards, let us direct energy toward studies to provide economic data with which to make the case for change. Demonstrating two differential work roles — professional and technical — in practice settings seems critically necessary as a prelude to restructuring legal requirements for two levels of practice and education. What evidence is there that a change to two levels will improve patient care?

Risk and Consequences of Political Failure

The initiative to change licensing laws and regulations by 1995 requires, for enactment, separate activities in each of 50 states. Whether proposed changes involve laws or regulations, such changes are subject to review and discussion by the citizens of the state. The shape and size of constituencies who believe they hold a substantive interest in the eligibility requirements for the RN title and license will vary by state. Not unintentionally, surely, states where ANA-supported activities have occurred or are occurring are states that have comparatively small constituencies from associate degree and diploma nursing. Most states have greater numbers of programs, faculties, graduates, and nursing service supporters who, for a variety of reasons, would oppose efforts to make associate degree and diploma graduates ineligible for the RN license and title in that state. Arguments opposing a change in legal requirements are difficult to counter. They include:

- Associate degree and diploma graduates' scores on the licensing examination for the license and title they are being denied are higher than those graduates who will now have exclusive access to the exam.
- No studies of nurse performance show that AD and diploma graduates are incompetent in the registered nurse role; in fact, studies show no differences in performance attributable to education.
- In sections of most states, associate degree nurses are the primary labor pool.

- There is irony in the provision that all persons holding an RN license at the point of change are "grandfathered" into the new, more restricted group, irrespective of educational preparation. The case for enhanced quality of care, difficult to make at best, is now compromised by the plan to incorporate into the professional category that group whose deficiencies presumably justify the change.
- Educational costs to students and taxpayers should not be increased in the absence of evidence that either benefits from the added investment.

The spectre of intensified public debate among nurses in the hearing rooms of state capitols is unappealing; worse, it compromises nurses' political credibility. One alternative is to delay efforts to change licensing structure until we've achieved educational remapping and/or sturdier demonstration of the benefits of longer educational preparation to provide a basis for rational and convincing responses to the five points listed above. Another alternative is to design new strategies for enacting the profession's educational goals that will enlist a broad base of unified support from the nursing community. The creation of an additional credential, over and above the RN, for graduates of baccalaureate or higher degree programs would be likely to enlist that support.

Consequences of Success

It is possible that success of the strategy may in the long run be more counterproductive than failure. There are dangers associated with the marked restructuring of the nursing occupation that a precipitous changeover might bring. Although thinking about these possibilities falls into the category of conjecture, they are grave enough to make them worthy of our consideration.

Unless educational remapping is achieved — and, in the annals of academic history, it is remarkable when a change of such magnitude occurs in a 10-year period — the new supply of RNs each year will be a fraction of current output. A greatly reduced number of registered nurses could give rise to a loss, not a gain in the profession's power. Hospitals, unable to fill positions traditionally held by registered nurses, could turn to predictable alternatives — the training of more flexible, institutionally credentialled technicians or aides to carry out the direct care tasks for which there is an insufficient supply of RNs. The new, elite, better-educated RNs would now be unable, by virtue of diminished numbers, to function in direct care-giver roles. Professionals could become exclusively high-level managers, teachers of professionals, and researchers. With separation from direct practice, and from the education of large numbers of non-professionals who give direct care, there could be a serious loss of control over practice on the part of professional nurses.

The structure of the nursing profession and its role and relationships in health care delivery would be very different. Of course, to make it different is the intention. But too much is at stake to pursue a high-risk strategy. We should immediately discontinue current efforts to change legal requirements in the state and consider new strategies and activities. I believe that it is possible to develop and implement responsible social and educational policies at nursing leadership levels that will give realistic direction to individual programs, faculty, and administrators, gaining the support and the certainty needed to meet society's needs for nursing care now and for the future.

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1. The term "educational remapping" is used by Margretta M. Styles and William L. Holzemer in their paper, Entry into practice: Let's talk numbers, presented at "Nursing in the 21st Century, A Conference," in Snowmass, Colorado in July 1985. I have used their metaphor in this paper, and have quoted the recommendations they offer for educational remapping. In all other respects, however, the opinions expressed in this paper are mine.
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Nursing HEALTH CARE

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Higher Education Under Scrutiny

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VOLUME 7, NUMBER 4 APRIL 1986

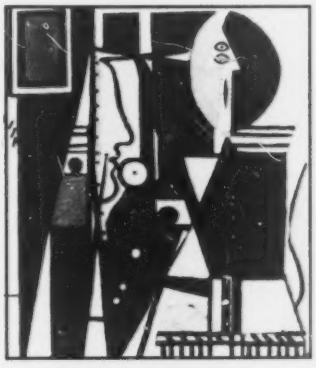
CONTENTS

Cover Story

Higher Education Under Scrutiny

In this issue, we continue our coverage of Ten Trends to Watch. The authors examine the state of higher education today and consider a variety of new avenues to keep it alive and responsive to society's needs.

Features

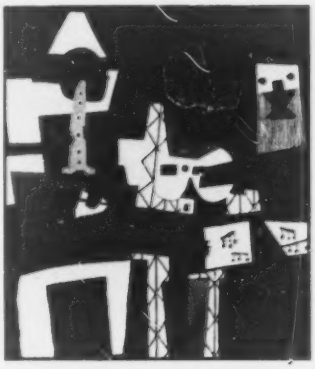


192

Redefining the Baccalaureate Degree

Four years ago, a special AAC committee looked closely at baccalaureate education and found it lacking. The author discusses the plan they devised to improve it.

Elizabeth Coleman



206

What Employers Will Expect

Nursing has the ability to survive in this critical era by changing and becoming part of a moving force that will meet society's needs, says the author.

Joan O'Leary

198

Defining the Product

The author considers crucial issues in baccalaureate nursing education that affect its product.

Alma S. Woolley

210

Nursing's Future

The author outlines critical environmental trends to consider as we plan for the future of nursing.

Geraldine Felton

202

The Business of Graduate Education

Taking into account the trends that are reshaping the health care delivery system, the author considers what graduate education should look like.

Ellen T. Fahy

Departments

172 Letters
173 Guest Editorial
175 Announcements
177 NLN Perspective
185 News
189 Washington Focus
214 The Marketplace
215 Bookends
216 Consumer Capsules
217 NLN Calendar
218 Accredited AD Programs
223 Classified

Feature photographs of Picasso paintings in this issue were taken at the Museum of Modern Art in New York City by Irene Bayer.

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Budget Crunch Threatens Nursing's Place in the Federal Ledger

By Sally B. Solomon, MSN, RN
Director of Public Policy & Research, NLN

"This is the year of the budget in Congress. It is a historic year of new challenges and unpleasant surprises." These words of House Speaker Thomas P. O'Neill (D-Massachusetts), which were quoted in a February 6 *New York Times* article, echo the sentiments of members of Congress, the administration, and lobbyists as they work under the burden of the federal budget deficit.

Budget Proposal

The budget that the president has proposed for fiscal year 1987 adds only 3.8 percent to the budget for the Department of Health and Human Services, which is the lowest increase for that department in at least a decade. The proposal does not include funding for nursing education or research. President Reagan made this same recommendation in his FY86 budget proposal, but, through vigorous lobbying, nursing was able to obtain a total of $64 million in appropriations. We'll have to work even more vigorously this year if we hope to maintain some funding because, although it is unlikely that Congress will adopt the president's proposal as is, it will be the starting point for their own budget deliberations.

The president has also proposed eliminating funding for the education of other health professionals. He wrote, "In view of projected national surpluses of health professionals by the end of this decade and their improving geographic distribution, continued federal aid for the training of health professions is no longer required. All major studies of supply and demand for health professionals conclude that virtually all occupations are in excess supply and that this will continue for the remainder of the decade." The president failed to distinguish nursing from other health professions; he also failed to take into account the Institute of Medicine's projections for an undersupply of nurses with baccalaureate and graduate degrees by 1990.

President Reagan has suggested cutting a number of other domestic programs as well. For example, he has proposed allotting only $6.8 billion to higher education, which is $2.2 billion less than education received for this year. And, as he did last year, he has proposed increasing premiums that Medicare beneficiaries pay for services covered by Part B—physicians' services, outpatient hospital care, and home health care. He recommends that the $15.50 monthly premium be raised to $17.80 by next January, and to more than $20 by 1991. President Reagan justified this proposal by pointing out that health care costs are going up more quickly than the general inflation rate, and that, since the Medicare program contributes to the federal deficit, it is subject to spending restraints.

The president has also proposed eliminating Medicare funding for nursing education. This spring, the administration will probably carry out this proposal by issuing regulations. The NLN believes that it is inconsistent for the admininstration to eliminate Medicare funding for clinical nursing education while it sanctions continuing support for clinical education in medicine. Our goal is to get legislation enacted that would supercede the regulations.

There is bipartisan agreement on Capitol Hill that Congress will not pass budget legislation based on the president's proposal in its present form. Observers believe that, to be acceptable to Congress, the FY87 budget will have to allocate less money for the military and grant more funds to domestic social programs than does the president's. They

also think it will have to include new ways to raise revenue.

Congress will probably debate the budget until the eleventh hour, while hundreds of special interest groups compete to get their programs funded. Nurses will have to speak loudly and clearly to be heard in that environment.

Rescissions

When the president submitted his budget proposal to Congress, he also asked that some of the funds appropriated for 1986 be rescinded. If Congress approves the request, nursing education and research will lose nearly $55 million. The $64 million appropriated for 1986 will drop to about $9 million. These cuts would affect every program authorized in the Nurse Education Act, including advanced nursing education, special projects, nurse-practitioner support, research, and national research service awards for nursing. The rescissions would eliminate funding for advanced nurse-traineeships and nurse-anesthetists, and for the newly authorized demonstration projects and faculty fellowships. They would also eliminate the $5 million that has been set aside as start-up funding for the newly created National Center for Nursing Research in the National Institutes of Health. The proposed rescissions are listed below.

1986 Funding and Rescission Proposals for Nursing Education and Research

Category	FY86 Appropriations	Funding based on 1986 rescission proposals
Advanced nurse education	16.5*	3.7*
Advanced nurse traineeships	11.5	0
Special projects	9.5	2.3
Demonstration projects	1.6	0
Nurse-practitioners	12.0	0.4
Nurse-anesthetists	0.8	0
Fellowships	0.5	0
Research	9.7	1.5
National Research Service Awards	2.0	0.7
TOTAL	64.1	8.6

**In millions of dollars*

For the rescissions to be enacted, both the Senate and the House of Representatives must approve them by April 15. If either chamber fails to act on them, they will not go into effect. Many legislative staff members believe there is a good chance Congress will reject the rescissions for nursing education and research because of the deep cuts for these programs included in the Gramm-Rudman bill and in the president's budget proposal. NLN believes that, since Congress and the president made a commitment to support these programs just two months before the president asked for the cuts, they should not back out of that commitment now.

NLN plans to testify before appropriations committees in both houses. We oppose the administration's budget and rescissions proposals because we know that the viability of many programs and the careers of many students rest on these funds. Discontinuing them would result in higher tuitions, which would add to the burden on students who are already finding it hard to finance their educations. In addition, the nursing profession is having difficulty recruiting talented students. These cuts could hinder nursing schools' development of new programs, which would make recruiting and keeping students even more difficult.

The League also opposes eliminating the funds for the nursing research center at NIH. Nurses worked hard for it, and the modest $5 million is due us.

Gramm-Rudman

Because the balanced budget legislation now known as Gramm-Rudman had no legislative precedents, Representative Mike Synar (D-Oklahoma) questioned its constitutionality. In February, a three-judge panel of the Federal District Court unanimously ruled that the part of the bill that requires the comptroller general (CG) to make the final recommendation for the president's sequestration order is unconstitutional. (The sequestration order is the automatic, across-the-board cut that the president makes in order to reach target spending levels.) According to the court, this requirement violates the "separation of powers" concept of the constitution, because it asks the CG, who is a member of the legislative branch of government, to perform a function that is under the domain of the executive branch. The court did not object to the constitutionality of other parts of Gramm-Rudman, such as the provisions for across-the-board cuts and for deficit reduction targets to be established by Congress.

The Supreme Court plans to hear the case this month and to announce a decision by June. Even if the justices declare the bill unconstitutional, the process it mandates and the cuts it requires could still go into effect. There is a back-up procedure written in the bill that enables Congress to approve budget cuts by a majority vote in both houses. Also, by the time the Supreme Court issues a decision, Congress and the administration already will have approved many of the budget cuts.

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NLN has just released Integrating Public Policy into the Curriculum, *edited by Sally Solomon and Susan Roe. This teacher's manual gives nurse faculty the theoretical background and the practical resources needed to teach public policy. A free copy of* Key Concepts in Public Policy: Student Workbook *will be sent with each manual. Forty color slides with accompanying script are also available. To order* Integrating Public Policy *(15-1995 $16.95);* Student Workbook *(15-1995A $7.95), or the slides (42-1996 $49.95), please add 75¢ handling for prepaid orders and allow $3 plus actual shipping charges for billed orders. Send to the Publications Order Unit at NLN headquarters.*

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Nursing HEALTH CARE

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Home Care: Compassion or Corruption?

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VOLUME 7, NUMBER 6 JUNE 1986

CONTENTS

Cover Story

Compassion or Corruption?

The home health field promises to meet many needs, but holds the potential for corruption. Authors in this issue add to our trends coverage by looking at how to ensure quality. Pages 300 and 304.

Features

300

Keys to Quality

Careful staff selection, training, and review are among the methods the author recommends to home care agencies striving to provide top-notch services.

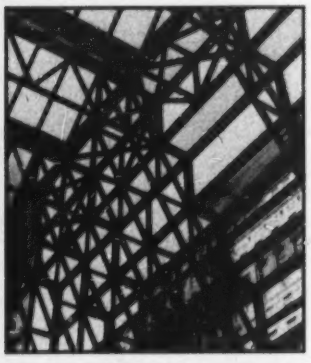
Deloris Griffith

314

Focus on Health

To make the distinction between nursing and medicine clear and to communicate the right message to clients, the authors say nursing must sharpen its focus on health.

Beverly A. Hall
Janet D. Allan

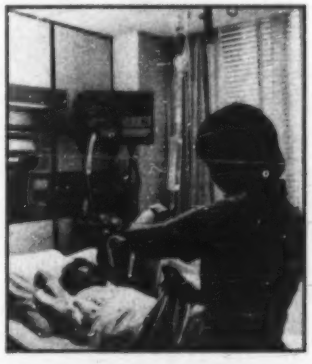


304

Guiding Patients' Choices

Because she believes that navigating the home care system can be daunting, the author says professionals should take the opportunity to help patients choose the best course.

Jo-Ann Friedman

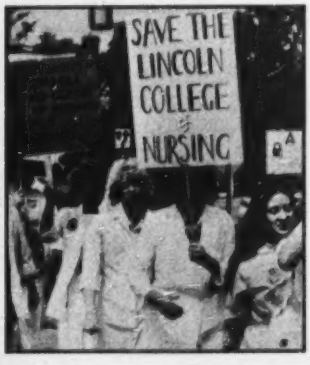


322

Defining Nursing's Role

Putting nursing diagnoses and interventions into practice will make nurses proud of the unique services they offer, as well as improve the health of their clients, says the author.

Lorraine Walker



308

Program under Seige

The author hopes this account of a successful fight to save a nursing college division will help others win their battles too.

Rosalee C. Yeaworth

Departments

279 Guest Editorial
281 Announcements
283 NLN Perspective
293 Research Commentary
296 News
298 Washington Focus
330 NLN Calendar
332 Accredited Baccalaureate and Higher Degree Programs
339 Classified

Special in this issue: A report on results from NLN's 1984 Annual Survey of RN Programs. See page 327.

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Nursing Education: Statistics You Can Use

By Peri Rosenfeld, PhD
Director of Annual Surveys, NLN

Over the past few years, nursing leaders' efforts have improved the political, social, and economic status of the profession. For example, the new National Center for Nursing Research promises to help nurses increase their influence on public policy and expand the body of nursing theory and research. Social changes affect contemporary nursing as well. Public- and private-sector cost containment initiatives have cut back the number of dollars available to pay for the nation's health care. The new environment gives nurses a wealth of opportunities to put their abilities to deliver cost-effective care into play. It also creates the challenge of trying to gain ground in a competitive marketplace.

At a time when the demand for highly skilled nurses to provide care in a variety of settings is growing, higher education has hit upon hard times. Enrollments are low, and nursing schools, along with other institutions of higher learning, are witnessing an influx of older, first-time students as well as returning students. These changes demand a rethinking of traditional teaching methods and curricula.

Under sharp economic constraints, nursing educators must take a hard look at how to teach students to rise to the new responsibilities that the efforts of the profession have won. The results of the National League for Nursing's (NLN's) 1984 Annual Survey of RN Programs offers data to help educators and policy makers plan for the demands of an altered marketplace.

The survey is a large-scale, year-long project. Each fall, NLN's research department revises the previous year's questionnaire, clarifying unclear questions and writing new ones to cover new issues. The researchers then send a survey packet to every nursing school in the United States and territories that prepares registered nurses (RNs).

Nursing education is now well-established in the higher education community. In 1984, 82 percent of all 1,477 basic nursing programs were affiliated with community colleges, four-year colleges, or universities. Of these, 777 offered an associate degree in nursing and 427 offered a baccalaureate degree. The remaining 273 nursing programs (18 percent of the total) were hospital-based diploma programs.

The changing proportion of program types over the past 20 years proves there is trend toward higher education in nursing. The number of baccalaureate and associate degree programs has increased steadily during the past two decades; the number of hospital-based diploma programs continues to decline. In 1965, diploma programs outnumbered baccalaureate programs 4-to-1 and associate degree programs almost 5-to-1. The 1975 picture was closer to the one we see today: there were 608 associate degree, 326 baccalaureate, and 428 diploma programs.

A breakdown of program type by NLN region indicates that, in the North Atlantic region, each type represents approximately one-third of the total: of the 357 programs, 30 percent are baccalaureate, 38 percent are associate degree, and 32 percent are diploma. All other regions report that the largest portion of their programs grant associate degrees: 47 percent of the programs in the Midwest, 59 percent of the programs in the South, and 74 percent of the programs in the West. Diploma programs make up the smallest proportion of programs in all regions except the North Atlantic: 24 percent in the Midwest, 10 percent in the South, and 2 percent in the West.

The proportion of program types within regions has changed most drastically in the North Atlantic and Midwest over the last decade. In 1975, 50 percent of the 402 programs in the North Atlantic were diploma, 28 percent associate degree, and 23 percent baccalaureate. Of the 388 Midwestern programs, 38 percent were diploma, 39 percent associate degree, and 23 percent baccalaureate. More modest changes have occurred in the South and West, but these regions do not have the long tradition of hospital-based diploma programs found in the other regions.

The survey's admission numbers include first-time nursing students admitted to a program between August 1983 and July 1984. Programs reported an overall increase of 3,245 students (2.7 percent), making the 1983–84 total 123,824. Broken down by program type, baccalaureate programs reported a 5.7 percent increase, associate degree programs reported a 4.1 percent increase, and diploma programs reported a 7.8 decrease percent in overall admissions.

From 1977–78 through 1979–80, annual admissions to RN programs fell. Although diploma programs experienced the greatest losses during that time, baccalaureate admissions also fell, and admissions to associate degree programs grew very little. Admissions have grown from 1980–81 on, perhaps due to more effective recruitment methods.

A look at the 10-year trend in annual admissions reveals that baccalaureate admissions have increased almost 13 percent since 1974–75, associate degree admissions jumped about 35 percent, and diploma admissions fell 28 percent.

Fall admissions decreased almost 4 percent, from 94,539 in 1983 and 91,085 in 1984. Since fall admissions make up approximately 70 percent of annual admissions, the reported drop signals the probability of lower enrollments in 1984–85.

As of October 15, 1984, enrollment figures reveal de-

Summary Table of 5- and 10-Year Trends in Nursing Education: 1975–1984*

Program	Number of Programs			Enrollments			Graduations		
	1975	1980	1984	1975	1980	1984	1975–6	1979–80	1983–4
Diploma	428	311	273	60,213	41,048	37,256	19,861	14,495	12,200
Associate Degree	608	697	777	88,121	94,060	104,968	34,625	36,034	44,394
Baccalaureate	326	377	427	99,837	95,858	95,008	22,579	24,994	23,718
Master's	99	135	166	9,662	15,503	18,882	3,417	4,755	5,082
Doctorate	12	22	31	508	1,919	1,696	62	125	183

*Source: Nursing Student Centers with Policy Implications 1985. New York: NLN, 1986.

creases in all program types. Diploma programs experienced an 11.3 percent drop; baccalaureate and associate degree programs decreased about 4 percent each.

Enrollment trends over the past decade show that, in 1974, baccalaureate degree programs reported 94,413 enrollments, which was a continuation of their upward trend; associate degree programs reported 84,166 enrollees, which also represented an expansion in numbers; and diploma schools reported a continued decline, with 63,972 enrollees. By 1979, baccalaureate programs still led the pack in enrollments, but the gap between baccalaureate programs and associate degree programs narrowed signficantly, and the gap between those programs and diploma programs widened—there were 98,939 enrollments in baccalaureate programs, 92,069 in associate degree programs, and 43,651 in diploma programs. In 1981, for the first time, enrollments in associate degree programs outnumbered those in baccalaureate programs, and this trend is continuing.

Enrollments in other areas of higher education are also plummeting. In April, 1985, the American Council on Education (ACE) reported a sharp decline in enrollments at the community college level, and National Center for Education statistics predicts a slight decline in college enrollments [1,2]. The Association of American Medical Colleges also reported a drop in enrollments and applications for fall 1985 [3]. So, although nursing education has its own internal problems, other areas of higher and professional education are also feeling the impact of such external factors as the shrinking college-age population.

The total number of students graduating from basic RN programs rose 3.8 percent to 80,312 in 1984. The 23,718 baccalaureate graduations represented a 0.6 percent decline over 1983. Associate degree graduations rose 6 percent to 44,394, and diploma graduations rose 4 percent.

The five-year trend reveals that the number of graduations from generic baccalaureate programs has been declining continually since 1979–80, when the total was 25,048. Associate degree graduations, which have been waning and waxing during the last five years, reached a high point in 1983–84, but the increases are modest when compared with the 30 percent gains registered each year during the 1960s and 1970s. The rise in the number of graduations from diploma programs can be explained by the rise in admissions in 1980 through 1983.

The pool of nursing students preparing for RN licensure reached its apex in 1983–84. From 1975–76 to 1979–80, the number of basic nursing graduates had remained in the high 70,000s; the past few years witnessed small fluctuations; and the current surge brought the number of graduates up to 80,000. However, we expect that graduations from diploma programs will continue to decline after two years of small increases. In light of declining enrollments and fall admissions, graduations from associate degree programs may stabilize in the next few years, and generic baccalaureate graduations will probably not outnumber their 1978–80 heights. In short, it's unlikely that we will see numbers of graduations as high as the current number in years to come.

Because the NLN and the American Nurses' Association have both endorsed the baccalaureate degree as the professional credential for nursing, we will probably see more nurses returning to school to earn baccalaureate degrees. But returning students also reflect an overall trend in higher education. According to a study of attitudes toward higher education reported in the newsletter *Higher Education and National Affairs*, increasing numbers of Americans are planning to upgrade their educations [4].

We should also consider the phenomenon of nurses returning to school in the context of the growing numbers of nontraditional college students. According to a report of the College Board, today's urban student is more likely to be female, over 25 years of age, and enrolled part-time [5]. These adult learners have special needs that educators in all fields will have to meet.

During the last 10 years, RN enrollments in baccalaureate programs have boomed. The number of RNs entering generic baccalaureate programs in nursing with a track for returning RNs grew from 10,653 in 1975 to 22,520 in 1984. The number of RNs entering special programs designed specifically for them rose 261 percent, from 5,063 in 1975 to 18,552 in 1984.

The combined enrollments of both basic and RN students in baccalaureate programs is 136,120: 70 percent are basic students, 16 percent are RNs in generic programs, and 14 percent are RNs in special programs designed for RNs. Most of the RNs are part-time students: 70 percent of those in generic programs are enrolled part time, and 74 percent in special programs are part-time students. Basic baccalaureate students are more likely to be full-time enrollees, only 10 percent are part-time students.

Regional data shows that 40 percent of the RNs enrolled

in generic programs are in the North Atlantic region, 25 percent are in the Midwest, 20 percent are in the South, and 15 percent are in the West.

The 10-year trend in the number of returning RN graduations is as dramatic as the enrollment figure. In 1974–75, 3,165 RNs graduated from generic baccalaureate programs. That figure rose to 6,275 in 1983–84. Graduations from special programs increased from 598 in 1974–75 to 3,810 in 1983–84. About equal numbers of RNs graduating from baccalaureate programs had diploma or associate degrees as their previous nursing credential.

The number of men enrolled in all types of nursing programs has increased steadily since 1978. In 1984, men accounted for 6.2 percent, or 13,652, of total enrollments in RN programs. Overall, about 3 percent of nurses are male.

The nursing student population, in addition to being largely female, is largely white. About 7 percent, or 15,363, of the 1984 enrollees were black. An additional 2 percent—4,410—were Hispanic, 1.6 percent—3,594—were Asian, and less than half a percent—880—were American Indian.

The proportion of minority nursing students our survey revealed is slightly lower than that reported by the United States Department of Education for undergraduate enrollments in institutions of higher education: blacks accounted for almost 10 percent of all enrollments, Hispanics for 4.4 percent, Asians for 2.7 percent, and American Indians for 0.7 percent [6].

Baccalaureate programs reported the highest percentage of black (6.5 percent) and Asian (2.2 percent) student enrollments. Associate degree programs reported the highest proportion of men (6.5 percent) and American Indians (0.6 percent). Diploma programs ranked third in all categories. These figures suggest that all types of nursing programs should step up efforts to recruit minority students.

Today's economic and demographic circumstances have created a need for nurses in expanded roles. A 1983 Institute of Medicine report revealed that there are insufficient numbers of nurses prepared at the graduate level to do research, serve as administrators and managers of clinical services in health care institutions, and practice in clinical specialties [7].

The data on graduate nursing education reveals that programs are working to meet the rising demand—the numbers of students enrolled in both master's and doctoral programs has increased. In 1984, the United States had 31 doctoral programs in nursing and 168 programs that granted master's degrees in nursing. Enrollments in doctoral programs jumped more than 13 percent, to 1,696, and enrollments in master's programs increased 4 percent to 18,822. Graduation figures reveal a similar pattern: the number of graduates with master's degrees increased 1 percent to 4,082, and 183 nurses received doctorates—a 32 percent increase over 1983.

Ten years ago, 12 doctoral nursing programs had 506 total enrollments and 74 graduations. In 1979, there were 980 enrollments and 125 graduations. Enrollments grew more than 200 percent, and graduations jumped almost 150 percent in the last decade.

The 5- and 10-year trends in master's education show that the number of programs increased from 99 in 1975 to 125 in 1979, and to 166 in 1984—a 68 percent increase in a decade. Enrollments increased from 8,584 in 1975 to 14,994 in 1980, and to 18,822 in 1984. Graduations jumped from 2,678 in 1974–75 to 4,755 in 1979–80, and to 5,082 in 1983–84.

The majority of master's students—81 percent—are preparing for advanced clinical placement. Seven percent are preparing for teaching; 11 percent are preparing for administration. The pattern we found among graduates is similar.

Approximately 15 percent of the master's program enrollees and graduates were in formal nurse practitioner programs, which we define as "an organized educational program consisting of formal classes and clinical practice designed to prepare registered nurses to perform in an expanded role in the delivery of primary health care." Family and adult health were the most popular specialty areas; small percentages of students specialized in pediatrics, gerontology, and midwifery. Given the growing numbers of elderly persons in this country, and the growing emphasis on community-based care, we expect there will be a greater demand for nurse practitioners in gerontology community health in years to come.

Contemporary nursing education must handle the internal professional demands of increased credentialing and the image of nurses while dealing with the challenges posed by external developments, such as the health care budget crunch, demographic shifts, and changes in higher education.

The data on nursing education programs helps point out some of the obstacles nursing faces—such as falling enrollments and fall admissions, as well as decreasing proportions of minority students. Educators have expressed concern about retaining nursing students, and this concern is partially borne out by the data on decreasing enrollments during times of increased admissions. Furthermore, fears of a nursing shortage may be supported by the possible decrease in graduations in the next few years. On the other hand, particularly in the area of higher degrees, there is encouraging news on RNs returning to school, and on enrollments in master's and doctoral programs. We hope these data will provide insights to help plan the future of the professions and to spur discussion among nursing leaders.

A full report of the annual survey appears in Nursing Student Census with Polity Implications 1985, *which is available from the Publications Order Unit, National League for Nursing, 10 Columbus Circle, New York, NY 10019, 800/847-8480, in New York, 800/442-4546.*

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Jane Doe, RN

Opening the Door on Nursing's Cost Advantage

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CONTENTS

Cover Story

Opening the Door on Nursing's Cost Advantage

Today's health care scene offers opportunities for nursing to expand its role to contain costs, says author Claire M. Fagin, who helps us continue our coverage of trends to watch. **Page 352.**

Features

358

Innovations Help Reach Goals

The author says that, by shaping, rather than riding along with market trends, nursing can realize its full potential to meet society's care needs.

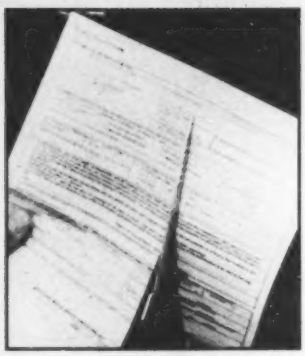
Ira P. Gunn

372

College Fights for Life

The author details a college faculty's successful fight to prevent the closing of a nursing college division.

Nancy F. Langston



364

The Cutting Edge

In light of the changes in the health care system, nurses are on the cutting edge of professional opportunity, according to the author.

Stanley Peck

376

Community Practicums

These practicums help RN students develop the autonomy and independence they'll need for practice.

Marianne Taft Marcus
Kay Swint
Ana M. Valadez
Kathyrn Ward
Rebecca Williams

368

Consumers Look to Nurses

Consumers' out-of-pocket costs for care are going up, explains the author, and their problems are opening up chances for nursing to broaden its role.

Vita R. Ostrander

Departments

343 Guest Editorial
348 Letters
351 Announcements
382 NLN Perspective
392 News
398 Washington Focus
400 The Marketplace
401 NLN Calendar
402 Accredited Diploma Programs
406 Classified

NURSING & HEALTH CARE offers diverse views on subjects of interest to readers. Articles represent the opinions of individual contributing authors and are not necessarily those of the National League for Nursing.

Opening the Door on Nursing's Cost Advantage

CLAIRE M. FAGIN

The health care system in the United States is in the midst of revolutionary change. The language of change includes such words as *cost containment, deregulation, diagnosis related groups, preferred provider organizations, independent practice associations, managed care*, and *peer review organizations*. However, the real change is a change in ideology spurred by the privatization of health care services. Access to care, once providers' paramount concern, now competes with their attention to the bottom line.

Nurses should be at the heart of any planned system change that will enhance cost-effectiveness. There is strong evidence that nurses and nursing care can affect patient outcomes positively, both in and out of hospitals, and that nursing services can contribute immeasurably to the goals of a competitive health care delivery system. Because of these findings, some public officials and business people have encouraged insurers and the government to reimburse nurses for their services. On the other hand, a number of forces have worked to deter nurses from entering the more autonomous health care marketplace. The net effect of the changes in the health care scene is far from clear. However, the new environment provides opportunities for nurses to increase our impact on the delivery system. The following facts about today's health care scene are particularly relevant to nurses' interests and expertise [1]:

Declining mortality rates Over the past decade, mortality rates have declined rapidly for all ages and both sexes. This is an unprecedented phenomenon following two decades of stationary rates for men and slowly declining rates for women [2]. Some scientists attribute this change to early diagnosis and treatment of life-threatening diseases; others believe it results more from improved self-care or healthier life-styles than from medical therapies or technologies [3].

Higher morbidity rate Paralleling the lowered mortality rate has been a higher morbidity from infancy through old age and a worsening health profile for middle-aged and older people. People aged 45 years and older experience fewer acute conditions than younger people, but spend more days caring for these acute conditions and suffer from a variety of chronic situations. The leading chronic conditions for men and women are hypertension, arthritis, and sinusitis [4].

The over 65 population About 12 percent of our present population is aged 65 years or older. As recently as 15 years ago, census experts had not foreseen this dramatic demographic change.

The escalation in health care costs In the past five years, health care costs have risen at a rate almost three times that of the general inflation rate. Elderly persons account for about one-third of all health care expenditures, and up to 30 percent of all Medicare payments are for care in the last year of life. However, analysts do not see the growth in the elderly population as the main reason for cost escalation. Rather, according to a report from the Office of Technology Assessment, the "dramatic increases are largely due to intensification of services, expanded availability and use of costly diagnostic and treatment services and technologies, and the rising cost of labor. This excessive inflation in health care costs has led to concerted efforts to contain spending, which have far-reaching implications [for all of us and particularly] for older Americans [5]."

Prospective payment The fears of the policymakers at the Health Care Financing Administration (HCFA), which were generated by the possible bankruptcy of the Medicare Trust Fund, led them to devise a new way to pay hospitals for the services they provide to Medicare patients. The prospective payment system (PPS) that was put in place on October 1, 1983 sent shock waves throughout the system. HCFA policymakers are now talking about reducing or eliminating financial support

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for graduate medical education, reducing physicians' fees under Medicare, reducing hospital rates, and applying diagnosis related groups (DRGs)—the patient classification system on which PPS is based—to physician payments. Although PPS only affects Medicare, it has added impetus to the concerns of other third party payers to contain costs. To date, only five states have instituted all-payer systems that mandate some form of prospective payment, but we anticipate acceleration in this movement. Both Representatives Richard A. Gephardt (D-Missouri) and Senator Edward M. Kennedy (D-Massachusetts) have introduced legislation to create all-payer rate setting systems throughout the United States.

Table 1. Patient Economic Exposure Under Private Health Insurance, 1982–1984

	1982	1984
Percentage of insurance plans requiring front-end deductible for inpatient hospital charges	39%	63%
Percentage of insurance plans requiring front-end deductible for inpatient surgical changes	34%	59%
Percentage of insurance plans where annual deductible total per family of $200 or more	4%	21%
Percentage of insurance plans paying 100 percent of hospital charges for first days of hospital stay	67%	42%
Percentage of insurance plans paying 100 percent of surgical fees	42%	26%

Source: Hewitt Associates Company, Company Practices in Health Care Cost Management, *1984. Companies sampled = 1185; Summary Table: Goldsmith, J., Death of a paradigm,* Health Affairs, *3(3), 1984.*

Attitude Changes

All of this activity has changed the way people think about the delivery system and has led to the rapid growth of the for-profit sector in health care delivery. Until recently, health care was seen as a public good that should be available to all Americans in some form, regardless of their ability to pay. The marketplace is now challenging this idea, and that challenge is getting less notice than we might have expected. People are paying a great deal of attention to the changes brought about by PPS without recognizing that many of the changes that affect costs occurred before PPS was put in place. Either prior to or concurrent with the federal initiative, corporations, third party payers, and other organized, well-funded groups had begun to change health benefit packages to bring costs down.

Hewitt Associates, an international firm of consultants in compensation and employee benefits, surveyed 1,185 companies in 1982 and in 1984 to discover whether they were changing their health care cost management efforts [6]. They discovered that companies have been aggressively redesigning plans to increase employee cost sharing, and that the number of firms requiring employees to pay deductibles almost doubled during that period (see Table 1). Hewitt Associates also found significantly increased employer intervention in employee decisions about medical care in the form of required preutilization reviews and second opinions (see Table 2). These changes, coupled with a May 1985 recommendation by the U.S. Treasury Department that all workers pay taxes on a portion of their health insurance benefits, show an almost complete about-face in attitudes toward employee health and benefits [7].

Market Changes

Clearly, health care buyers are pushing rapid and dramatic changes. The way providers are responding to market forces runs the gamut from either paralysis or helter-skelter activity to a targeted business approach to create new markets or to gain a share of the changing market through competitive pricing and service and to siphon the paying portion of the existing market from the already beleaguered public and voluntary sector. As examples, private ambulatory care centers—dubbed urgicenters, emergicenters, medical care walk-in centers, and docs-in-a-box—are cropping up around most middle class urban and suburban areas, which already had plenty of providers available. And even the home health segment of the marketplace, which has been seen as a nonprofit enterprise in the true sense of the phrase, has experienced an infusion of for-profit activity. Visiting nurse associations (VNAs) and public health departments have long offered high-quality services at low costs, and for-profit organizations' initial entries into this field were not successful. That situation has changed radically. VNAs and public health departments held an 85 percent share of the market in 1966. That share had declined to 37 percent by 1984. VNAs' share alone dropped from 39.7 percent in 1966 to 11 percent in 1984. Proprietary home health organizations have made large strides in penetrating the market during the past three years (see Table 3).

Ours, then, is a health care system facing a revolution fueled by an increasingly older population, necessary changes in primary focus from cure to care, changing values about who gets how much care, alternative health care systems and providers, and extraordinary growth in for-profit providers.

The Nursing Scene

On the most simple level, both the social and the systems changes should create enormous reliance on the skills and attitudes that form the heart of nursing. We should not be surprised, however, that we are progressing by fits and starts. Although we are gaining ground in battles to win direct reimbursement from state and national programs, we continually face both challenges to such inclusions and the threat of physicians' incursion into nursing areas. Data support our bid for direct payments and expanded roles, showing the effectiveness of a wide variety of nurse practitioners in meet-

ing health care needs at a high level of quality and acceptance, and often at lower costs than other providers [8,9]. In fact, a recent survey revealed that, of the sampled populations, 63 percent of the public cross section, 59 percent of the hospital administrators, and 73 percent of the union leaders deemed acceptable a system change that would encourage the use of nurse practitioners and midwives rather than physicians [10]. Among physician leaders, 75 percent considered such a change unacceptable.

The reaction of organized physician groups to major and minor changes in state and federal laws that would prompt consumers to use nurse practitioners and other alternate providers is not surprising. Even when access to physicians was a problem, physicians' organizations condemned expanded roles for nurses. Now the American Medical Association has expressed concern about "a doctors' glut, and an impending oversupply of physicians in all specialities [11]."

Successes

Nurses have made some important strides despite strong physician pressure to block us from being included in reimbursement programs. For example, during 1985 and 1986, the number of states with health insurance laws that mandate reimbursement for nurses' services increased. And nurses have several strong supporters in Congress who are working to help us progress. In May 1986, Representative Mary Rose Oakar (D-Ohio) reintroduced legislation that would allow direct reimbursement to nurse practitioners, nurse anesthetists, certified nurse midwives, and certified registered nurses under the Federal Employee Health Benefits Program (FEHBP). President Reagan vetoed the FEHBP bill in 1985 on the advice of organized medicine, but, at this time, the reintroduced bill has 24 sponsors.

Representative Richard Gephardt supports eliminating the tax exemption for employer paid health insurance benefits because he believes the money gained would be better used to provide health care for uninsured Americans. Gephardt plans to introduce legislation that would permit registered nurses to be paid by Medicare Part B for services they provide without direct supervision by physicians. He hopes this measure will encourage nurses to form independent group practices, which ultimately would reduce hospital use by making low-cost preventive care available and, therefore, more attractive to consumers.

If nurses do not capitalize now on the dramatic changes in the health care marketplace, there is no doubt that other providers will. We have to be sure that we do not sit back and watch as other health care professionals take steps to meet the country's changing health care needs.

Corporate concern about the high cost of care has also increased consumer access to nurse providers. Corporate cost containment efforts have led to many changes in benefits packages, as well as to a variety of innovative health care delivery packages. Such managed care systems as health maintenance organizations and preferred provider organizations generally bid to provide services for employees in local industries at capitated rates. National networks of health care companies, called super-meds, serve corporations with multiple locations. All of these programs make extensive use of a wide variety of nursing services in direct care, review, and marketing.

The number of nurses who are taking matters into their own hands and beginning entrepreneurial ventures also continues to grow. Many of these nurses are making themselves more visible, meeting with colleagues who share their interests and problems and consulting others interested in combining nursing with business. The June 1986 American Nurses' Association convention marked the first time a special interest group of such nurses met on a national level.

Although we can expect growth in the number of nurses in nontraditional roles, we should also be aware that hospitals are a major arena in which nurses can make the most of our cost advantage. Sixty-eight percent of registered nurses worked in hospitals in late 1984. Getting the most from our cost advantage requires continuing efforts to find acceptable cost accounting

Table 2. Employer Intervention in Physician Decision Making, 1982–1984

	1982	1984
Percentage of firms requiring preadmission utilization review	2%	26%
Percentage of firms requiring concurrent hospital utilization review	8%	34%
Percentage of firms requiring retrospective hospital utilization review	18%	40%
Percentage of firms paying 100 percent of cost for second surgical opinion	—	53%
Percentage of firms mandating a second surgical opinion	—	28%

Source: Hewitt Associates Company, Company Practices in Health Care Cost Management, *1984. Companies sampled = 1185; Summary Table: Goldsmith, J., Death of a paradigm,* Health Affairs, *3(3), 1984.*

systems that will allow us to develop our own cost and revenue centers. Community health nursing leaders attest to the fact that they have always had to measure nursing productivity and manage cost and revenue directly. Many writers now are stressing the importance of measuring nurses' contributions in hospitals. Ann van Slyck has said "it is apparent that, as nurses, our vulnerability is in part a result of previous attempts to justify our existence with quality-of-care arguments alone. We are now finding it necessary to justify our services financially—from a cost benefit perspective [12]." Franklin A. Shaffer points out that nursing is in its second generation of attempts to price our products [13].

We are in the process of building our documentation of nursing interventions and costs that can provide the data necessary for third party reimbursement for nursing care in any setting. Examples include continuing study of the use of RN staff members in delivering nursing care, documenting the effectiveness of broad use of hospital-employed nurses for preadmission and postdischarge care or monitoring, and developing new systems for measuring nursing intensity and case management.

Suggestions

For nurses to take full advantage of the cost-effectiveness of the services we provide, our momentum for progress must continue into the future. To keep that momentum strong, we should give special attention to certain areas. First, the question of third party reimbursement is murky at best. Nurses are struggling to obtain direct reimbursement at a time when fewer physicians are receiving direct payment. About 40 percent of the physicians practicing today are salaried, and this percentage is quickly rising. Government program leaders are strongly averse to reimbursing new providers because they believe that doing so will thwart their cost cutting goals. Therefore, we must continue to gear our political actions for reimbursement in revenue neutral formats—that is, we must convince program leaders that our being paid directly for services will not lead to higher budget outlays. In the area of nursing homes, where we are working to improve the quality of care being provided, it may be difficult to maintain revenue neutrality if we win appropriate reimbursement for our efforts. Despite the difficulties, this is an area in which the public requires that we keep our efforts strong.

Table 3. Medicare-Certified Home Health Agencies by Sponsor

Sponsor	1966	1976	1984
Visiting Nurse Association	39.7%	20.3%	11%
Government	45.4%	49.7%	26.3%
VNA, Government, Combined	91.6%	71.8%	38.5%
Proprietary	—	3.7%	27%

Sources: Department of Health, Education and Welfare, Health Care Financing Administration, Medicare-use of home health services: 1976, Health Care Financing Statistics, *May 1980. Proprietaries pass officials in Medicare-certified HHA,* Home Health Line, *July 23, 1984. Stewart, J.,* Home Health Care, *Mosby, 1979. Vogel, R., and Palmer, H., Long-term care: Perspectives from research and demonstration, Department of Health and Human Services, Health Care Financing Administration, 1983.*

Second, nurses must show evidence that we can provide quality care not only directly, but also indirectly through patient education. Capitation systems limit the cost of care to a fixed price per person each year. All delivery systems that receive capitated payments want to provide quality service to as many patients as possible at the lowest cost. A hallmark of such programs is to enhance the ability of patients and families to manage more of their own care and to require fewer services. For decades, nurses' educational programs have stressed self-care—helping people analyze the factors that affect their health and well-being and take actions that will change these factors. As clients assume more responsibility for their own health, their reliance on the health care system will be reduced.

It makes sense for managed care systems to delegate as much as possible to less expensive providers. There is strong evidence that nurse midwives and nurse practitioners provide high quality, highly accepted care at less cost than do physicians. In many instances, the care is more holistic and health promoting and uses fewer high-cost procedures and less hospitalization. Nurses' strategies for growth should include making certain that the owners and managers of these delivery systems are fully informed about the cost and quality advantages of employing nurses.

Third, the hospital marketplace now offers a wealth of opportunities for highly skilled nurses. Contrary to early predictions that declining occupancy rates would reduce hospital employment opportunities for nurses, increased patient acuity has upped hospitals' needs for registered nurses while lowering the need for nonprofessional personnel. Hospital-based RNs can also take the lead in planning care for the total illness episode—discharge planning, rehabilitation, home care, and long-term care are all within nursing's realm of professional knowledge. Thus, nurses must capitalize on professional knowledge during times of major structural changes.

Another important market for nurses to target is community- and corporate-based wellness programs. These programs offer education on prevention, increase health related behaviors, and discover and mitigate risk factors. Occupational health nurses, school nurses, and community nurses must increase their activities in these spheres either as part of their current work mode or through volunteer activities. Such activities will increase the visibility of nurses and will demonstrate their skill in developing, collaborating with, and implementing such programs.

Finally, if nurses do not capitalize on the opportunities in the changed marketplace, there is no doubt that other providers will. We have to be sure that we do not sit back and watch as others meet the country's changing health care needs.

Conclusion

The continued blurring of roles in primary health care, the glut of physicians in the marketplace, and the creation of new markets and new roles are complex factors that will influence

nurses' efforts to make the most of our cost advantage. We can and must address recent aggressive entries of physicians into geriatric care and home care, as well as the continued testimony of physicians against liberalizing state and national programs to include nurse practitioners. We have a number of political allies interested in opening the health delivery system to us and to other credentialed providers. It is our responsibility to collect the data to support and monitor change in order to protect the integrity of the profession and the health of the public.

The facts about today's health care scene—the higher chronicity, the increased percentage of aged persons in the population, the public's recognition of the importance of leading healthier lives and taking steps to prevent illness, and everyone's interest in keeping costs down—force us to take a new look at our profession. We have appropriately cherished our concern with quality; finally we can blend it with a concern for gaining autonomy, recognition, and suitable compensation. Individual nurses and nursing leaders can push the profession ahead by continuing to capitalize on the new climate in health care.

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